STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344002	A. BUILDING _____ B. WING _____	C 10/18/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROUGHTON HOSP	1000 S STERLING ST MORGANTON, NC 28655

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 199	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on medical record review, staff interview, hospital policy review and document review, the hospital's nursing staff failed to have effective systems in place to ensure a patient's condition was monitored and ongoing nursing care was provided to meet a patient's medical needs as evidenced by: A) failing to monitor and document changes in a patient's medical condition in accordance with hospital policies and procedures for 1 of 4 sampled patients (#2). . ~cross refer to 482.23 Nursing Services, Staffing and Delivery of Care (b)(3) Tag A0204. B) failing to ensure the hospital had a policy and procedure which addressed orders for force fluids for 1 of 4 sampled patients (#2). ~cross refer to 482.23 Nursing Services, Staffing and Delivery of Care (b)(3) Tag A0204. C) failing to develop and implement nursing care plan interventions for a patient with UTI (urinary tract infection) for 1 of 4 sampled patients (#2). ~cross refer to 482.23 Nursing Services, Nursing Care Plans (b)(4) Tag A0205.	A 199		
A 204	482.23(b)(3) RN SUPERVISION OF NURSING	A 204		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344002	A. BUILDING _____ B. WING _____	C 10/18/2005

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A 204	Continued From page 1 CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on medical record review, administrative staff interviews, and review of hospital policy and procedure, nursing staff failed to provide appropriate supervision and care to meet a patient's medical needs for 1 of 4 patients reviewed (patient #2). Findings include: Medical record review conducted on 10-17-05 revealed patient #2, a 74-year-old female, who was admitted to the hospital on 8-22-05 with the diagnosis of Schizophrenia, Chronic, Paranoid Type with Acute Exacerbation. According to the Off Campus Transfer Summary/Consult Referral, patient #2 was transferred to the emergency room of an outside medical facility on 9-5-05 at 12:30pm with a physical diagnosis of Acute Renal Failure and Electrolyte Imbalance. On 10-17-05, the discharge summary (dated 9-6-05) from the acute medical facility was reviewed and revealed "(patient #2's name) came in with an initial nausea and vomiting over the past week, apparently had gotten worse and was noted to have low blood pressures and was brought in through the emergency department. She was noted to be in acute renal failure at that time". The discharge summary also stated "We had also consulted surgery for possible small bowel obstruction, however, during the course of her stay, which was quite fast, she arrested and	A 204		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344002	A. BUILDING _____ B. WING _____	C 10/18/2005

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A 204	Continued From page 2	A 204		

was unresponsive and a code was called and apparently the patient expired during that code". According to the document, patient #2 died on 9-6-05 (one day after patient #2 was transferred to the acute medical facility).

Further review of patient #2's medical record revealed laboratory results of a urine culture, dated 8-26-05 at 1337 (1:37pm), which stated "3 organisms present - Recollect if indicated". On 8-26-05 a nurse practitioner documented on the lab results "Recollect". Review of the physician's orders revealed an order written by a nurse practitioner, dated 8-26-05 (Friday) at approximately 2:00pm (unable to decipher exact time), which stated "Repeat UA/C&S (urinalysis/culture and sensitivity) (previous specimen contaminated)".

Further review of the medical record revealed laboratory results of the repeat urine culture, which indicated patient #2's urine specimen was collected on 8-29-05 (Monday) at 6:00am (approximately 64 hours after the order was written to recollect the urine sample). The report was dated 8-31-05 at 9:27am, and a nurse practitioner documented "levaquin 250 mg (milligrams) po (by mouth) daily x 7d (days) repeat UA/C&S x 10d". Review of the physician's orders revealed an order, dated 8-31-05 at 1300 (1:00pm), which stated "1. levaquin 250mg po daily x 7d" and "2. Repeat UA/C&S 10 days". In a progress note, dated 8-31-05 at 1300 (1:00pm) the nurse practitioner documented "Pts. UA/C&S positive Kubriella/E.coli..."

On 10-18-05 the hospital policy and procedure entitled "Physician Laboratory Orders" was reviewed. The policy revealed "1. Routine - Any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344002	A. BUILDING _____ B. WING _____	C 10/18/2005

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A 204	Continued From page 3	A 204		

test(s) ordered without specific time instructions. This test(s) will be processed and batch analyzed during the normal 8 a.m. to 5 p.m. workday...". Interview with the Director of Nursing (DON) on 10-18-05 revealed the policy "Physician Laboratory Orders" was no longer in use.

The new "Physician Laboratory Orders" policy stated "1. Routine - Any test(s) ordered without specific time instructions. This test(s) will be processed and batch analyzed during the normal 8 a.m. to 5 p.m. workday and 8-12 Weekend or Holiday". In an interview on 10-18-05 the DON reported the new policy went into effect on 10-11-05. Further interview with the DON confirmed a repeat UA for patient #2 was ordered on 8-26-05 (Friday) and was collected by nursing staff on 8-29-05 (Monday) "as per the policy at the time". The DON reported patient #2's urine sample was not sent on the afternoon of 8-26-05 because it was not written as a STAT order. The DON reported "With our review our policy has changed to as soon as the order is written to collect the specimen, we will collect the specimen and send it to the lab and the lab will prioritize when they run the test". Additionally, the DON reported the new policy addressed timelines regarding specimen collection and sending specimens to the lab.

Further review of patient #2's medical record revealed a nursing progress note, dated 9-1-05 at 2100(9:00pm), in which the nurse documented "S. (subjective) 'My stomach feels hot'. O. (objective) Pt. vomited large amount of tea colored fluid and undigested food." The note indicated bowel sounds were present in all four quadrants, and patient #2's stomach was "soft and flat".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344002	A. BUILDING _____ B. WING _____	C 10/18/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 204	Continued From page 4 In a progress note, dated 9-2-05 at 8:40am, the nurse practitioner documented "Pt. c/o (complains of) nausea/vomiting - some loose stools that began last night. Received a laxative yesterday. Having mild abdominal cramping...Abdomen not distended; soft. BS (bowel sounds) active x 4 quad (quadrants). Generalized tenderness elicited upon palpation of the abdomen. No guarding or rebound tenderness." The nurse practitioner further documented "A(assessment): nausea/vomiting/gastroenteritis P(plan): switch antibiotics to see if this makes a difference in pt condition. Phenergan now then q 6 (every six hours) prn (as needed) nausea/vomiting. Force fluids. Levsin SL for stomach cramps." Review of the physician's orders revealed an order, dated 9-2-05 at 8:30am, in which the nurse practitioner ordered the following for patient #2: a now dose of phenergan, phenergan every 6 hours prn nausea, and levsin SL every 4 hours prn abdominal cramping. Additionally, the nurse practitioner changed patient #2's antibiotic from levaquin to "Bactrim DS 1 po bid (twice a day) x 7d." Another order, dated 9-2-05 at 8:45am revealed "1. Force fluids (diet)" and "3. Clear liquids x (for) breakfast and lunch. Full liquids with supper; then resume pts normal diet." There was no evidence of a hospital policy and procedure regarding "force fluids". The hospital policy entitled "Intake and Output" was reviewed on 10-18-05. The policy stated "Procedure: Good nursing judgement is always important when deciding to place a patient on I&O (intake and output). Any patient can be placed on I&O at the nurse's discretion". There was no evidence in patient #2's medical record or in interview with	A 204		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344002	A. BUILDING _____ B. WING _____	C 10/18/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROUGHTON HOSP	1000 S STERLING ST MORGANTON, NC 28655

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A 204	Continued From page 5	A 204		

administrative staff that patient #2 was placed on I&O.

The ADL (activities of daily living) documents for patient #2 were reviewed on 10-18-05. The documents contained sections for "oral fluid intake". For 9-2-05 through 9-5-05, staff placed an "x" for each meal for oral fluid intake (except for supper on 9-3-05, staff documented "4" which indicated 75%). There was no evidence that revealed the amount of fluid intake patient #2 received during meals or if staff was forcing fluids in between meals. There was no evidence of consistent nursing documentation regarding the amount of patient #2's fluid intake. Based on nursing documentation, it could not be determined if the nurse practitioner's order (9-2-05 at 8:45am) for "force fluids" was being implemented for patient #2.

Further review of patient #2's medical record revealed a treatment team progress note, dated 9-2-05 at 1836 (6:36pm), which stated "(Patient #2's name) vomited last night and again this a.m. after breakfast..." The note further indicated patient #2 received a phenergan suppository that morning (9-2-05) for nausea and patient #2 was on a "clear liquid diet for 24 hours".

A nursing progress note, dated 9-3-05 at 6:30am, revealed patient #2 had no nausea/vomiting during the night and she reported feeling "under the weather." The nurse further documented "Took fluids this am without problem. On clear liquid diet this am. A. (Assessment) c/o feeling bad, requesting to stay in bed. P. (Plan) Continue to monitor. Lying in bed @ present".

Review of the medical record revealed the next

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344002	A. BUILDING _____ B. WING _____	C 10/18/2005

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BROUGHTON HOSP	1000 S STERLING ST MORGANTON, NC 28655

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A 204	Continued From page 6	A 204		

narrative progress note regarding patient #2's condition was written on 9-4-05 at 2200 (10:00pm), which was approximately 40 hours after the previous progress note on 9-3-05 at 6:30am. The nurse documented "S. (Subjective) 'Oh that hurts!' O. (Objective) Pt. vomited on 2nd shift x 3. She ate 1/2 supper then vomited yellow green fluid at about 1800 (6:00pm) and then again at 2000 (8:00pm)". The nurse further documented patient #2 was given phenergan 25mg po at 2030 (8:30pm), which was ineffective due to emesis (vomiting). According to the note, patient #2 was then given 25mg phenergan PR (suppository) at 2145 (9:15pm). The nurse documented "Abdomen distended, (decreased) bowel sounds, soft stool in rectum. Pt. c/o discomfort, cries out when abdomen palpated. (Physician Assistant's name) advised of above...".

Documentation by the Physician Assistant (PA) on 9-4-05 at 2210 (10:10pm) stated "...I was asked to see her (patient #2) due to c/o pain and distended abdomen...Abd (abdomen) soft - c/o tenderness all over...". Additionally, the PA documented patient #2 had "no rebound/guarding" and bowel sounds were "present in all four quadrant". The PA note also stated "Pt. already on levsin and phenergan and being treated for UTI (urinary tract infection)...".

The hospital policy and procedure entitled "Documentation" was reviewed on 10-18-05. The policy revealed "Procedure: I. Progress Notes H. Whenever the patient has a significant change in condition or status (i.e., initiation/discontinuation of precautions, change in physical health..."). Medical record review revealed there was no documentation in the progress notes regarding patient #2's physical status from 9-3-05 at 6:30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344002	A. BUILDING _____ B. WING _____	C 10/18/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROUGHTON HOSP	1000 S STERLING ST MORGANTON, NC 28655

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A 204	Continued From page 7	A 204		

am until 9-4-05 at 2200 (10:00pm). On 10-18-05, administrative staff reported if nothing was documented in the progress notes, it was assumed patient #2 was not experiencing any medical problems.

Review of patient #2's Medication Administration Record (MAR) on 10-18-05 revealed patient #2 received 25mg Phenergan PO on 9-3-05 at 12:35pm for "nausea and vomiting." There was no further documentation in the progress notes regarding patient #2's condition when she received Phenergan (i.e. if patient #2 was only experiencing nausea or if patient #2 had vomited, and the amount/frequency of emesis). Further review of the MAR revealed patient #2 received Levsin SL for abdominal cramping on 9-4-05 at 12:15pm. There was no additional documentation in the progress notes that described patient #2's condition when she received the Levsin SL.

Further review of the medical record revealed a nursing note, dated 9-5-05 at 2:50am which revealed patient #2 fell in the hallway at 1:50am. According to the note, patient #2 reported "I'm OK, I just feel kind of weak and dizzy". The nursing note revealed patient #2's vital signs were as follows: P (pulse) 118, R (respirations) 20, BP (blood pressure) 90/60. The nurse documented "Pulses difficult to palpate in all 4 extremities". According to the nursing note, the PA was notified and the plan was to "Monitor pt. closely for remainder of shift and encourage fluids.

A nursing note, dated 9-5-05 at 10:55am revealed "Pt. ate 50% of breakfast and drank 240cc ginger ale - pt. able to keep down...". An addendum to the note revealed the lab had called

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A 204	Continued From page 8 with the following lab results: BUN=117, Creatinine=8.0, Na+ (sodium)=135, K+ (potassium)=5.6, and Cl (chloride)=80. The nurse documented the critical lab values were reported immediately to the PA. A progress note, dated 9-5-05 at 12:00pm and written by the medical physician, was reviewed. The physician indicated patient #2 was seen for increased BUN and Cr (Creatinine). Additionally, the physician documented "Pt c/o pain in lower abdomen, had diarrhea x 3 since last night, emesis x 3 last night, ate 50% of breakfast...Presently being treated for UTI (with) Bactrim". The note revealed patient #2's vital signs were as follows: P(pulse) 88, R(respirations) 35, T(temperature) 96.9, and "BP(blood pressure) unable to obtain". The physician also documented "Imp (impression) - Acute renal failure -Electrolyte imbalance -Dehydration -NIDDM(non-insulin dependent diabetes mellitus) -Hypotension" and "Plan - Transferred to (name of acute medical facility) ER".	A 204		
A 205	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. This STANDARD is not met as evidenced by: Based on medical record review and administrative staff interview, staff failed to maintain a current care plan for 1 of 4 patients reviewed (patient #2). Specifically, staff failed to update patient #2's comprehensive treatment plan to include an active medical problem (urinary tract infection).	A 205		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344002	A. BUILDING _____ B. WING _____	C 10/18/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROUGHTON HOSP	1000 S STERLING ST MORGANTON, NC 28655

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A 205	Continued From page 9 Patient #2's comprehensive treatment plan, dated 8-30-05 was reviewed on 10-17-05. There was no evidence patient #2's treatment plan had been updated to include a urinary tract infection that was diagnosed on 8-31-05 and was being actively treated with antibiotics. Other medical problems (Hypertension, Hyperlipidemia, and Type II Diabetes Mellitus) were included in patient #2's treatment plan. Interview with administrative staff on 10-18-05 confirmed patient #2's urinary tract infection was not added to the treatment plan.	A 205		